Commentary

The 'No Code' Tattoo—An Ethical Dilemma

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Out-of-hospital death in the United States has become a ritual punctuated by sirens, cardiopulmonary resuscitation, and advanced cardiac life support (ACLS). Emergency physicians are increasingly concerned with the misuse of ACLS, including the practice of continuing it in emergency departments in most patients who do not respond to prehospital attempts at resuscitation.[1-5] Patients are equally concerned. Individual patients do not know how to ensure that their wishes concerning resuscitation will be carried out. These uncertainties have been intensified by the US Supreme Court's decision in *Cruzan versus Missouri Department of Health* allowing states to require "clear and convincing" evidence to withdraw life support.[6] In this commentary I describe one person's attempt to control the circumstances of his own death.[7]

No Code Tattoo

On his 65th birthday, a physician with more than 40 years of clinical experience in emergency medicine and general (trauma) surgery who was board certified in both, had a tattoo symbolizing "Do not defibrillate or cardiovert" (DND) placed on his left chest. This tattoo (25 mm in diameter) (Figure 1), copied from a picture prepared by a medical illustrator, was positioned lateral to his left areola. The tattooed symbol was used because it is an international form of communication not requiring words. As such, his desires would remain comprehensive if he were to die during his frequent foreign travels. Placing the tattoo represented neither an end-of-life nor an end-of-career action. The physician had neither retired nor reduced his workload and had no serious or debilitating disease. He continued to teach, work clinically, and do research on a schedule at least as full as that of his younger colleagues. He formally retired at age 70 but continued to see patients and do research for part of the time.

Several questions are raised by this action:

- Why did this experienced clinician feel it necessary to get such a tattoo?
- How adequate are current advance directives, especially in prehospital care and in emergency departments?
- How should clinicians respond to such nonstandard directives in emergency situations?

Why Did This Physician Feel It Was Necessary to Have This Directive Tattooed on His Chest?

A DND tattoo can be seen as a response to retirement, illness, or depression or, to the contrary, as an affirmation of personal principles. If it is a statement of personal principles, the underlying motivations and the nature of a medical care system that requires such action are worth investigating.

I think ACLS is a farce (he says). Paramedics save lives by defibrillation, but we never save them in the emergency department unless the paramedics bring them through the door with a pulse. I don't mind dying, but I sure as hell do not want to spend days, months, or years in a nursing home bouncing beach balls in a parachute blanket.

This physician created his tattoo as an attempt to make a principled statement about the futility in emergency departments of continuing ACLS on patients who do not respond to prehospital resuscitative efforts. His active and productive life after acquiring the tattoo attests to his not using it as an end-of-life statement. The tattoo demonstrates his own dismal experience with continuing unsuccessful prehospital ACLS in an emergency department, an experience confirmed by other emergency physicians experienced in prehospital care.[1-5]

In contrast to several published accounts of emergency department resuscitations,[8] emergency physicians seem to be swinging toward the conclusion that nearly all patients arriving without vital signs in an emergency department either quickly die or have devastating neurologic sequelae. A recent study from Baylor College of Medicine, Houston, Texas, suggests that less than 0.01% of patients having prehospital cardiac arrest leave the hospital alive.[1] Other studies have shown similarly dismal results, concluding that between 0.4% and 0.6% of patients who undergo prehospital resuscitation leave the hospital neurologically intact.[4,5] Even in hospitalized patients, only 11% to 17% of those who have CPR done leave the hospital.[9,10] Newer terminology regarding the limitation of medical care orders implicitly recognizes these data. Once common, "do not resuscitate" (DNR) orders are now changing to "do not attempt resuscitation" (DNAR) orders.

The overuse of ACLS is a reflection of medicine's general attitude toward diseases and patients. Physicians are often more concerned with errors of omission than with those of

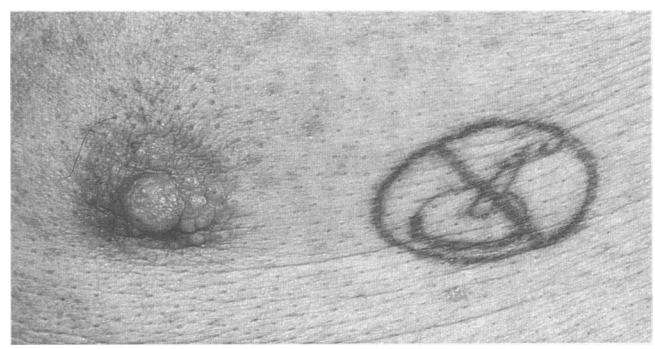

Figure 1.—The tattoo next to the patient's left areola (actual size, 25 mm in diameter) signifies an international code for "do not defibrillate."

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ABBREVIATIONS USED IN TEXT

ACLS = advanced cardiac life support
CPR = cardiopulmonary resuscitation
DNAR = do not attempt resuscitation
DND = do not defibrillate or cardiovert
DNR = do not resuscitate

commission.[11] One theory of error control in medical practice suggests that when an error is likely to occur, the course of action with the most preferred result (or least egregious error) is chosen. Following this reasoning, emergency physicians and the emergency medical system may be more troubled by failing to resuscitate those few people who possibly could be saved than by resuscitating the many people who cannot be saved or do not want attempts at resuscitation.[11] Even though it is generally accepted that adult competent patients can refuse medical treatment, this seems to have been ignored in cardiac resuscitations. As George Annas said,

> Although CPR is almost 20 years old, the general rule today often seems to be that no one can die in a hospital without CPR. This is medical practice in many institutions, *but it is not the law.* Patients have the legal right to refuse to be resuscitated [emphasis in original].[12(p216)]

The physician who had himself tattooed attempted to prevent resuscitation efforts that would only prolong his dying and impose unnecessary suffering before death occurred.[13-15] The purpose of his tattoo was to demonstrate his belief that ACLS is overused; it was not a reaction to life events. He acted in response to the modern technomedical death that as Philippe Aries says,

> has been dissected, cut to bits by a series of little steps, which finally makes it impossible to know which step was the real death. . . . the doctor and the hospital team . . . are the masters of death—of the moment as well as the circumstances of death. . . .[7(pp88-89)]

The results of this biotechnologic imperative have made traveling the road to death more laborious, painful, and costly. The tattooed physician is not the only emergency health care professional to feel the need to declare his position in favor of limiting resuscitation. Although there is no record of the frequency of DNAR tattoos, I know of one other example: an experienced and practicing emergency department nurse with "DNR" tattooed in the precordial area.

What Does a DND Tattoo Say About the Adequacy of Current Advance Directives, Especially in Prehospital Care?

One method used to guide the application of modern health care technology in accord with a patient's personal values is the signing of advance directives such as living wills, durable powers of attorney for health care, and DNAR orders. The rationale for the use of advance directives is a respect for patient autonomy, which asserts that patients should determine their own resuscitation status.[16] In the recent US Supreme Court decision in *Cruzan*, five justices declared that a constitutional liberty interest guarantees adults with medical decision-making capacity control over what happens to their own bodies.[6]

Advance directives are now commonly used within health care institutions but are less used elsewhere. In the past decade a consensus has been established that DNAR orders, a form of instructive directive, are ethically acceptable.[16] New federal law requires instruction as to the availability of advance directives for all patients in hospitals, hospices, nursing homes, and receiving home health care.[17] Even with such instruments, it remains difficult to control the circumstances surrounding one's own death outside of a health care institution.[18-20] If the emergency medical system is inadvertently activated at the time of death, prehospital resuscitation attempts are required almost everywhere in the US. Only about 23 of the many hundreds of emergency medical system jurisdictions and only two states by statutes—Montana and New York—currently have a comprehensive DNAR protocol that controls erroneously activated ambulance services and allows those dying at home, in a public place, or even in a long-term-care facility to avoid otherwise mandatory ACLS when it is neither desired nor appropriate.[20] Even where such prehospital DNAR protocols do exist, patient identification and an immediate awareness of the existence of a directive are problems this physician's tattoo reduces.[19] When patients reach the emergency department, the mandate for preserving life and the often overriding principle of beneficence limit the ability of patients to exercise autonomous decisions about resuscitation, especially through advance directives. Thus, although advance directives are becoming easier to obtain and to implement, and although federal legislation is making their use more prevalent, emergency medical system protocols that allow the implementation of DNAR in the prehospital setting are rare.

How Should Clinicians Respond to Such Nonstandard Directives in Emergency Situations?

Physicians have three options when confronted by patient directives, including a tattoo: they can follow them, ignore them, or use them merely as another piece of information to guide treatment.

Following a directive. Although there are many ways for patients to transmit information to physicians, even when they are unconscious, there are at least three requirements for every directive if it is to be implemented: it must be a true and uncoerced expression of the patient's wishes; it must be unambiguous; and the patient's directions must be morally and legally appropriate, not compromising the medical care giver.

It is often difficult for emergency care personnel, whether in the emergency medical system or the emergency department, to determine the identity let alone the wishes of their patients. They often must rely on third parties for this information. Extralegal surrogate decision making (where the surrogate is not statutorily appointed, not an agent under a durable power of attorney for health care, a legal guardian, and not the parent of a patient younger than 18 years) is fraught with problems and is best avoided in hectic emergency scenarios where life and death are at issue. In the case of the physician with the DND tattoo, however, no surrogate is necessary.

What is not clear is what the tattooed patient intended to have done (or not done) because of the tattoo. The tattoo symbolizes "do not defibrillate." Prehospital defibrillation is the one frequently lifesaving therapy in out-of-hospital cardiac arrests; 10% to 30% of patients found in ventricular fibrillation survive if defibrillation occurs within ten minutes of cardiac arrest.[21] The physician with the tattoo directive in fact said that he did *not* specifically want to forgo the possible benefits of prehospital defibrillation. He was caught in a dilemma, however, because he wanted an easily and interna-

tionally recognizable symbol indicating his wish not to undergo futile resuscitation attempts. His hope was that the tattoo would help dissuade an emergency department staff from continuing ACLS if he presented without vital signs. A "DNR" tattoo might be less ambiguous than the paddle (DND) tattoo, but a DNR tattoo also requires interpretation. Does DNR mean not to defibrillate, not to assist ventilation, not to administer intravenous fluids, or even not to administer a narcotic antagonist should it become necessary?

The ambiguity of many advance directives, both within medical facilities and in prehospital care, has led to more specificity in the directives.[22,23] Orders about whether to defibrillate, intubate, use vasopressors, operate, or hydrate are now often explicitly stated in hospital DNAR orders. This level of specificity, as well as its multitude of different legal and quasilegal formats, does not work in emergency care. Unlike the relationship between clinicians and their hospitalized patients, emergency personnel are initially unfamiliar with their patients, have limited time to effect many critical medical interventions, and may be unable to decipher nonstandard legal documents in the time available. If emergency care givers are to comply with a patient's advance directive, the directive must have a format that is standard, familiar, unambiguous, and that protects those who comply with its requests.[19] A partial solution to this problem is for more emergency medical jurisdictions to adopt prehospital DNAR protocols through which to set boundaries for prehospital resuscitation that are clear and acceptable to both patients and care givers.

If emergency care givers are to comply with a patient's advance directive, the directive itself must request moral actions, must be legal, and must not compromise the integrity of the medical profession. Advance directives carry no more weight than a competent patient's choice. Even a competent patient's ability to exercise choice about care is not absolute; societal values, expressed as state interests, can sometimes override the patient's autonomous wishes. Accordingly, advance directives may be overridden if state interests are more important.[16] These interests include the prevention of homicide and suicide, the preservation of life, protection of the interests of innocent third parties, and the maintenance of the medical profession's integrity (as enumerated in *Superintendent of Belchertown State School versus Saikewicz).*[24]

There is also a unique quality of emergency medical care that cannot be compromised: the willingness to respond to requests for help whenever asked. The emergency medical system has a duty to respond appropriately to those appearing in need of its help, without triaging on the basis of quality of life, socioeconomic status, or any other nonrelevant factor. In the absence of a prehospital directive specifying a patient's considered wishes under a standard DNAR protocol, emergency care professionals should give primary weight to the patient's immediate objective interests in avoiding significant harm and death.[25] This is the basis of all emergency medical care: if it is to be altered in response to patients' wishes, an explicit and public protocol to that effect must exist.

Ignoring the directive. Many emergency physicians are uncertain whether they may act on the basis of an advance directive in the emergency departments, especially once ACLS is in progress. This hesitancy may stem from their role as emergency care givers, from the concerns expressed earlier about the directives themselves, or from a questioning of the difference between withholding and withdrawing care. Although these factors will not cause emergency physicians to halt emergency department resuscitations, they may cause emergency department personnel to use only medical indications, not patient directives, to determine when to cease resuscitative efforts.

Although the physician's tattoo is an extreme and somewhat ambiguous format to express personal wishes, alternative methods are available and are commonly used to relay specific medical information. Patients carry Medic Alert* necklaces and bracelets, a wide variety of wallet cards, and occasionally medical records or actual advance directives to alert health care providers to their medical illnesses, hazards, or wishes. These devices most often advise medical care professionals that the patient suffers from a particular disease or allergy that may affect diagnosis and treatment. These various warnings and explanations are advisory only; they do not constitute a consent or refusal of a specific therapy.

Emergency care givers are more frequently seeing patients who, through relatives, their primary care provider, or their medical record, direct that specific treatment be withheld. Such refusals may conflict with the care givers' concepts of the principle of beneficence. Although these patients may be in the terminal stages of a progressive disease, they may also be patients with reversible conditions of abrupt onset.[26(p154)] In emergency care, with its limitations of time, patient information, and resources, the principle of beneficence weighs so heavily on providers that when a dilemma arises between whether to respect patient autonomy or provide beneficent care, beneficence controls. The bias toward attempting to preserve life is strongest in the emergency department. Emergency care givers may come to accept advance direction for terminal patients more easily, but it is unlikely that they will ever withhold lifesaving care from patients with acute illness or injury who could obviously receive a sustained and substantial benefit from treatment, even if an advance directive were known to exist.

Problems with advance directives are not limited to refusals to accept treatment; directives may also demand inappropriate treatment. Another complication may arise with the use of advance directives in the future, when they may direct physicians to continue "heroic" efforts, even when the physicians think that further treatment is futile. The Illinois durable power of attorney for health care legislation includes a proviso through which a patient may request all forms of life-maintenance treatment to be continued indefinitely.[27] If emergency medical professionals look first to the medical indications for resuscitation and rely heavily on beneficence (and its obverse, nonmaleficence) in their decision making, these demanding directives will probably have less force than other advance directives because patients have stronger legal and moral rights for refusing than for demanding therapy.

Use as information. Some emergency physicians may use standard advance directives as well as nonstandard directives including a tattoo as merely another piece of information to be used in making medical care decisions. The more ambiguous the directive, the less probative the information. Yet, when used in the context of specific medical indications for resuscitation or continued resuscitation, the patient's preferences in the matter may be important. Even with only a tattoo indicating that resuscitation is refused, a patient may influ-

*Medic Alert, 1000 N Palm, Turlock, CA 95380.

ence the circumstances of his death as strongly as if a formal advance directive were in effect and known to the emergency care givers. With a tattoo, at least a patient can be assured that whatever the circumstances, the tattoo will be in evidence to give some weight to his or her desires concerning resuscitation.

Conclusion

In general, because of its ambiguity and the potential for compromising the integrity of both the emergency medical system and the physicians involved, neither a tattoo nor similar nonstandard directives should be followed. Physicians should, however, weigh nonstandard directives in direct proportion to their reliability and with consideration of the surrounding medical situation.

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